II. INTRODUCTION

A. Purpose of Needs Assessment

The purpose of this report is to define and collect a core set of risk and protective indicators to better identify specific critical needs for individual populations at the state and local level. In the past the Bureau of Alcohol and Drug Abuse and its funded coalitions had endorsed the Seven Steps to Prevention Program Planning Model developed by the Center for Substance Abuse Prevention's (CSAP) Western Center for the Application of Prevention Technologies (West CAPT). The Seven Step model emphasized the reduction of individual and environmental risk factors for the prevention of negative health outcomes such as substance abuse and dependence. Conversely, it encouraged individual and environmental protective factors that exerted positive influences on youth during their development. Although this assessment now utilizes the Strategic Prevention Framework State Incentive Grant (SPF SIG) Five Step Model, along with a set of risk and protective factors. This model will be explained in detail on page 11. Currently, the SPF SIG five steps outlined by this model are as follows:

- Profile population needs, resources, and readiness to address needs and gaps
- Mobilize and/or build capacity to address needs
- Develop a comprehensive strategic plan
- Implement evidence-based prevention programs and activities
- Monitor, evaluate, sustain and improve or replace programs that fail

Statistical tables in this report contain actual numbers (N) as well as rates. One must use caution when comparing rates, whether it be in percent or per 1,000, because rates derived from low numbers (N) are not reliable. Only simple descriptive statistics that collectively may provide a sense of prevention and treatment needs at the state and county level are presented in this report. Data compiled in this report are generally from secondary sources. Data sources and data field definitions are provided in Appendix A.

This assessment is sectioned by the following domains: Community, Family, School, and Individual/Peer. Each section contains an introductory paragraph that explains the domain, followed by a table detailing responses to Youth Risk Behavior Survey (YRBS) questions that are pertinent to that specific domain. Subsequent pages for each section contain tables with domain related risk factor indicators and brief explanations of these indicators. Indicator data is provided at both the statewide and county level when available. The explanation and data source for indicators contained in these tables are presented in Appendix A. Appendix B consists of county and statewide summary sheets containing indicator data from all domains. Statewide and county client profiles for treatment services funded through the Nevada Bureau of Alcohol and Drug Abuse (BADA) are provided in Appendix C.

B. Introduction to Nevada

Nevada is the seventh largest state in the nation and is comprised of 17 counties spread across 109,826 square miles. Nevada is largely a rural/ frontier state with an estimated 2,366,315 residents (2004) and is traditionally divided into three regions that include Clark County (72% of the population), Washoe County (16% of the population), and the Balance of the State (12% of the population).

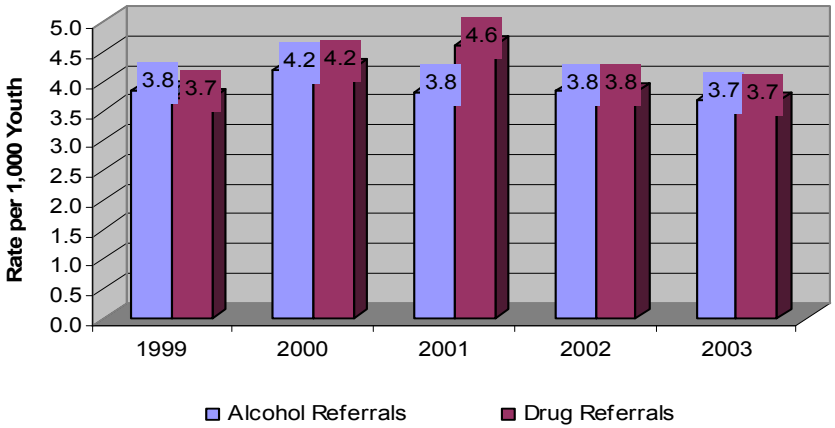
Nevada's population is unique in several ways. As a result of the pervasive gaming and resort industry, and a twenty-four hour lifestyle, Nevada has a large number of residents employed in low-paying service jobs. In 2004, 18% of Nevadans were employed by the casino hotel and gaming industry whereas nationwide this value was 1% (Standard Industrial Classification Code, SIC). In the ten-year period from 1994 to 2004 Nevada's population grew nearly 56% and many of those moving to Nevada have become employed by this industry. The result of the availability of this type of employment and the present state of the economy has been a highly mobile population. Nevada led all states in population mobility with 63% classified as movers and only 21% having been born in Nevada. It is estimated that: 19.4% of Nevadans, twenty-five and older, do not have a high school diploma, 7.5% of the families have incomes below the federal poverty level (2000 Census), and 11.1% of the families have a female as head of house with no husband present. In addition, 18.9% of Nevadans lack health insurance, ranking Nevada as 44th in the nation. Nevada ranked: 44th for violent crimes with 638 offenses per 100,000 population; 42nd for the rate of total mortality, 41st for adequacy of prenatal care; and 37th for the prevalence of smoking (2004, United Health Foundation State Health Rankings). The insurgence of people over the last ten years has also affected the ethnic diversity of Nevada and it is paramount that these populations have access to alcohol and drug abuse prevention and treatment services (Table 1).

Table 1: Racial and Ethnic Growth in Nevada from 1994 to 2004

Ethnic Category	Age Category	Clark County Growth		Washoe County Growth		Balance of State Growth		Nevada Growth	
		Numbers	%	Numbers	%	Numbers	%	Numbers	%
African American	All Ages	56,962	37%	2,065	25%	680	26%	59,707	36%
Native American	All Ages	6,474	45%	1,858	26%	1,670	16%	10,002	31%
Asian	All Ages	71,655	60%	8,377	39%	1,677	35%	81,709	56%
Hispanic	All Ages	260,422	62%	36,836	50%	13,075	33%	309,867	58%
White	All Ages	300,749	31%	36,980	14%	47,824	20%	385,553	26%

Substance abuse among high school students and adults alike present a problem in Nevada. A highly mobile population, the abundance of lower paying service jobs, and Nevada's 24-hour lifestyle exacerbates this problem. Binge drinking has traditionally been higher in Nevada than the national average for both youth and adults. In 2003, 27.8% of Nevada's high school students reported having five or more drinks of alcohol in a row, within a couple of hours, in the past 30 days (Youth Risk Behavior Survey; YRBS). In response to the Behavioral Risk Factor Surveillance Survey (2004; BRFFS), the 18% of Nevada adults binge drink, compared with the national average of 15%. In the BRFSS questionnaire heavy drinking is defined as "adult men having more than two drinks per day and adult women having more than one drink per day." In 2004, 7% of Nevada's adults indicated that they drink alcoholic beverages heavily compared to the national average of 5% (BRFSS). Utilizing pooled data from 2002 and 2003, the National Household Survey on Drug Use and Health (NSDUH) estimates that 8% of Nevada's population, 12 years of age or older, have an alcohol abuse or dependence problem, and 3% have a drug abuse or dependence problems. This translates to 143,000 individuals and 53,000 individuals respectively.

Figure 1: Alcohol and Drug Related Juvenile Referrals by Rate per 1,000 Youth Ages 0 to 17 Years Old, 1999-2003



Nevada Juvenile Justice System reported 2,129 referrals for alcohol related infractions and 2,114 referrals for drug related infractions in 2003 (Figure 1). Adolescents are starting to use alcohol, tobacco, and illicit drugs at increasingly younger ages, and young adults, who are just beginning to assume more mature responsibilities in society, are more likely than other groups to drink heavily, smoke cigarettes, and use illicit drugs. Nevada youth have been affected by the availability of tobacco, alcohol, and drugs in the community, and in several instances exceed the national averages for various behaviors reported in the YRBS (Table 7). The link between alcohol and illicit drug use with crime and aggressive behaviors are clearly visible in society today.

Data from the National Survey on Drug Use and Health (NSDUH: Table 3) indicates that Nevada residents in almost all three age categories (12-17, 18-25, and 26+) had a higher rate of past month use for marijuana and cigarettes than the national average.

Prevention programs that identify high risk and substance using individuals at the local level before they progress to dependence is essential in reducing future chronic alcohol and drug abuse cases. Many of these individuals could benefit from early identification and intervention, which can reduce tremendous psychological and financial burdens on the individual, family and community. In addition, the fiscal impact on the criminal justice system, health care system, and drug abuse treatment programs will be positively impacted by early identification of substance abuse problems.

C. Definitions

Risk Factors: Conditions that increase the likelihood of young people becoming involved in substance abuse, for example; delinquency, teen pregnancy, school dropout, and/or violence.

Protective Factors: Conditions that protect youth from the negative consequences of exposure to risks, by either reducing the impact of the risk or changing the way young people respond to risk. Protective factors promote positive youth development and include strong bonds with family, parental monitoring with clear rules of conduct, and success in school performance.

Community Domain: Focuses on groups of individuals who share cultural and social experiences within a common geographic or political jurisdiction.

Family Domain: Focuses on parents (or persons serving as parents) and children who are related either through biology or through assignment of guardianship, who are actively involved together in family life sharing a social network, material, and emotional resources, and sources of support.

School Domain: Focuses on the environment where children begin to interact with a larger group of adults and other children while mastering new social and cognitive skills.

Individual/Peer Domain: Focuses on the problems and needs of individuals.

D. Risk and Protective Factors

Research completed by the National Institute on Drug Abuse (NIDA) has identified several protective factors that help to prevent drug use among children and adolescents. These factors are not always the opposite of risk factors and their impact varies along the developmental process. These protective factors are:

- Strong bonds with family
- Experience of parental monitoring with clear rules of conduct with the family unit and involvement of parents in the lives of their children
- Success in school performance
- Strong bonds with pro-social institutions such as the family, school, and religious organizations
- Adoption of conventional norms about drug use

Continue Risk and Protective Factors

The NIDA has also identified many risk factors for drug abuse, each representing a challenge to the psychological and social development of an individual and each having a different impact depending on the phase of development. For this reason, those factors that affect early development in the family are probably most crucial. Other risk factors relate to children interacting with other socialization agents outside of the family, specifically the school, peers, and the community. Factors such as availability of drugs, trafficking patterns, and belief that drug use is generally tolerated also influence the number of young people who start using drugs. The NIDA Risk Factors and Related Problem Behaviors (Table 2) are on the following page, and are organized by community, family, school, and individual/peer domains. The table also depicts the relationships of these domains to identified problem behaviors including substance abuse, delinquency, teen pregnancy, school dropout, and violence.

Table 2: National Institute on Drug Abuse Risk Factors and Related Problem Behaviors

	Adolescent Problem Behaviors				
Risk Factors	Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence
Community					
Availability of Drugs	✓				✓
Availability of Firearms		✓			✓
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	✓	✓			✓
Media Portrayals of Violence					✓
Transitions and Mobility	✓	✓		✓	
Low Neighborhood Attachment and Community Disorganization	✓	✓			✓
Extreme Economic Deprivation	✓	✓	✓	✓	✓
Family					
Family History of Problem Behavior	✓	✓	✓	✓	✓
Family Management Problems	✓	✓	✓	✓	✓
Family Conflict	✓	✓	✓	✓	✓
Favorable Parental Attitudes and Involvement in the Problem Behavior	✓	✓			✓
School					
Academic Failure Beginning in Late Elementary School	✓	✓	✓	✓	✓
Lack of Commitment to School	✓	✓	✓	✓	✓
Individual/Peer					
Early and Persistent Antisocial Behavior	✓	✓	✓	✓	✓
Rebelliousness	✓	✓		✓	
Friends Who Engage in the Problem Behavior	✓	✓	✓	✓	✓
Gang Involvement	✓	✓			✓
Favorable Attitudes Toward the Problem Behavior	✓	✓	✓	✓	
Early Initiation of the Problem Behavior	✓	✓	✓	✓	✓
Constitutional Factors	✓	✓			✓

E. National Survey on Drug Use and Health: 2002-2003 Pooled Results

The Substance Abuse and Mental Health Administration (SAMHSA) conducts a yearly National Survey on Drug Use and Health (NSDUH). SAMHSA administers questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. The survey covers residents of households, non-institutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. Persons excluded from the survey include homeless people who do not use shelters, active military personnel, and residents of institutional group quarters, such as jails and hospitals. Within the combined survey years there was over 1,800 surveys conducted of residents 12 years of age or older in Nevada.

The total estimate (all ages 12 and greater) of the past month use of alcohol, tobacco, illicit drug and marijuana is 51%, 35%, 10% and 8% respectively. The corresponding national figures for the past month use of these substances are 51%, 30%, 8% and 6%. Nevada ranks higher than the national average among illicit drug, tobacco and marijuana use.

The NSDUH report provides national estimates of rates, numbers of users, and other measures related to use of illicit drugs, alcohol, cigarettes, and other forms of tobacco by population, ages 12 years and older. This report also includes state-by-state estimates of substance use prevalence. Nevada results from the 2002 and 2003 pooled data are on the next page.

Table 3: Results Pooled from the 2002 & 2003 National Survey on Drug Use and Health

		Total		Age Group (Years)					
				12-17		18-25		26 or Older	
	Region	Numbers in Thousands*	Rate in Percent	Numbers in Thousands	Rate in Percent	Numbers in Thousands	Rate in Percent	Numbers in Thousands	Rate in Percent
Illicit Drugs (2002 and 2003 Pooled Data)		Rate Estimates (Percent)							
Past Month Any Illicit Drug[1]	United States	19,947	8.25	2,845	11.44	6,350	20.24	10,302	5.72
	Nevada	183	10.3	23	12.46	47	22.02	113	8.17
Past Month Marijuana Use[1]	United States	14,612	6.18	1,997	8.03	5,388	17.17	7,227	4.01
	Nevada	136	7.62	18	9.58	39	18.29	78	5.68
Past Month Use of Any Illicit Drug Other than Marijuana[1]	United States	8,813	3.73	1,419	5.70	2,562	8.17	4,831	2.68
	Nevada	80	4.47	9	5.12	20	9.35	50	3.62
Past Year Cocaine Use	United States	5,905	2.50	473	1.90	2,093	6.67	3,339	1.85
	Nevada	42	2.38	4	1.97	16	7.35	23	1.66
Perception of Great Risk of Smoking Marijuana Once a Month	United States	92,317	39.05	8,372	33.66	7,589	24.19	76,356	42.38
	Nevada	606	34.02	62	33.52	49	22.76	495	35.86
Average Annual Marijuana Initiates	United States	2,593	1.81	1,399	6.57	1,061	6.82	133	0.13
	Nevada	20	2.02	12	8.42	6	6.08	1	0.15
Alcohol (2002 and 2003 Pooled Data)									
Past Month Alcohol Use	United States	119,414	50.50	4,395	17.67	19,114	60.91	95,905	53.22
	Nevada	902	50.68	34	18.40	122	56.37	747	54.12
Past Month Binge Alcohol Use[2]	United States	53,782	22.75	2,650	10.65	12,944	41.25	38,188	21.20
	Nevada	371	20.87	20	10.90	73	33.81	278	20.17
Perception of Great Risk of Drinking Five or More Drinks Once or Twice a Week	United States	99,388	42.04	9,541	38.36	10,216	32.56	79,632	44.20
	Nevada	743	41.75	71	38.57	75	35.01	597	43.24
Tobacco (2000 and 2003 Pooled Data)									
Past Month Tobacco Use[3]	United States	71,115	30.09	3,688	14.83	14,125	45.02	53,302	29.59
	Nevada	623	34.99	28	15.31	91	42.38	503	36.47
Past Month Cigarette Use	United States	60,777	25.71	3,126	12.57	12,708	40.50	44,943	24.95
	Nevada	543	30.50	24	12.73	78	36.40	441	31.95
Perception of Great Risk of Smoking One or More Packs of Cigarettes Per day	United States	168,506	71.27	15,839	63.67	20,541	65.46	132,126	73.33
	Nevada	1,238	69.57	119	64.24	135	62.56	985	71.38
Past Year Dependence or Abuse (2002 and 2003 Pooled Data)									
Any Illicit Drug Dependence[1]	United States	4,505	1.91	738	2.97	1,683	5.36	2,084	1.16
	Nevada	34	1.91	6	3.41	12	5.52	16	1.15
Any Illicit Drug Dependence or Abuse[1]	United States	6,975	2.95	1,332	5.35	2,517	8.02	3,127	1.74
	Nevada	53	2.98	11	5.98	17	8.03	25	1.78
Alcohol Dependence	United States	7,893	3.34	520	2.09	2,155	6.87	5,218	2.90
	Nevada	61	3.44	4	2.23	15	6.84	42	3.07
Alcohol Dependence or Abuse	United States	17,952	7.59	1,462	5.88	5,470	17.43	11,020	6.12
	Nevada	143	8.01	13	6.93	35	16.19	95	6.88
Alcohol or Illicit Drug[1] Dependence or Abuse	United States	21,796	9.22	2,211	8.89	6,706	21.37	12,879	7.15
	Nevada	174	9.75	19	10.26	46	21.32	109	7.87

F. Bureau Priorities

This document presents a wide variety of information related to substance abuse and dependency problems faced by the citizens in the state of Nevada. As indicated in section II-E, which presents information from the NSDUH, there are large numbers of Nevadans that need but do not receive substance abuse treatment services. Consequently, the Bureau's treatment funding priorities are focused on closing this gap for adolescents and adults.

Substance abuse prevention needs of our youth and young adults are implied in this assessment, but when combined with the information in sections II-C and II-D, which discuss the Risk and Protective Factor Methodology, the Bureau's priorities are not obvious, especially as they relate to youth. In order to improve substance abuse prevention services in the state, the Bureau has been working for several years to enhance the state's prevention capacity and infrastructure. While funding for direct services has grown slightly over this period, the biggest focus of activity has been on the substance abuse coalitions.

Currently there are 12 coalitions funded by the Bureau that serve 17 counties throughout the state; however, an additional coalition will be funded to served the needs of the Native American population by the end of 2005 (please refer to Table 4 for a list). These coalitions have identified their priorities utilizing the Seven Steps To Prevention Program Planning methodology. These priorities are presented in Table 5 on page 13.

G. State Incentive Grant

The Bureau's strategic plans under Nevada's State Incentive Grant (SIG) are to develop and promote coalition strategies. Out of five years the Nevada SIG is in the third year of funding from the SAMHSA, Center for Substance Abuse Prevention (CSAP). In late 2002, the Governor's Office was notified that Nevada had been awarded $3 million per year for three years to develop substance abuse prevention capacity and infrastructure. With the Planning Cycle complete, the SIG program has conducted a fundamental review of how services are organized and funded with an eye on reducing the burden of disparate state funding streams, reporting requirements, and timelines on the community.

With SIG monies, the Bureau has funded 12 coalitions (1 coalition later in the year) serving all counties and two special populations, covering the entire state, and representing the state's Native American population and the Hispanic/Latino populations in the southern Nevada area. These coalitions serve as regional prevention centers, developing and implementing local comprehensive community prevention plans. Coalitions also have a responsibility to identify and fund evidence-based prevention services to fill identified gaps without duplicating services, and provide monitoring and financial oversight to the programs funded in their communities.

H. Strategic Prevention Framework State Incentive Grant (SPF SIG)

SAMHSA has awarded the Governor's Office $2.3 million per year, for five years, to bolster prevention capacity and infrastructure in Nevada. This State Prevention Framework State Incentive Grant (SPF SIG) will insure a solid foundation for delivering effective, culturally competent, evidence-based substance abuse prevention services in both rural and urban settings. This program targets consumption and consequences of substance use. Additionally, it targets reducing childhood and underage drinking. Goals of the Nevada Strategic Prevention Framework grant are to:

- Prevent the onset and reduce the progression of substance abuse across the lifespan
- Reduce substance abuse-related problems in communities
- Build prevention capacity and infrastructure at the state and community levels

This grant requires the formation of a State Epidemiology Workgroup (SEW) to gather and analyze data to better identify prevention needs at local and state levels. Five steps, detailed in the SPF SIG grant, are designed to increase program sustainability, cultural competence, and capacity (Figure 2). BADA now has an epidemiologist on staff and an epidemiological workgroup (SEW) established to assist with this needs assessment.

Figure 2

Table 4: Current Prevention Coalitions in Nevada, the Counties Served and Year Formed

	Coalition	Area of Service
Coalitions Supported in CY 2000		
1	BEST Coalition	Clark
2	Churchill Community Development Coalition	Churchill
3	Community Council on Youth	Carson City
4	Eastern Nevada Prevention Coalition*	White Pine
5	Healthy Communities Coalition of Lyon and Storey Counties	Lyon, Mineral & Storey
6	Join Together Northern Nevada	Washoe
7	Mineral County Coalition *	Mineral
8	Partnership of Community Resources	Douglas
Coalitions Formed in CY 2001 and CY 2002		
1	Frontier Community Coalition	Humboldt, Lander & Pershing
2	Goshen Community Development Coalition	Clark (N. Las Vegas)
3	Nye Communities Coalition	Nye, Esmeralda
4	Partners Allied for Community Excellence	Elko
Plans for CY 2005 Included the Funding of 13 Coalitions Including the Following:		
1	Southern Nevada Latino Coalition (LUZ)	Southern Nevada
2	Statewide Native American Coalition	Statewide
3	7^{th} Judicial District Coalition	Eureka, Lincoln, White Pine

*These coalitions are no longer supported by BADA.

Table 5: Local Risk Factors and Problem Behaviors Identified by BADA Funded Prevention Coalitions

Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence	Risk Factors	Best Coalition	Churchill Community Coalition	Community Council on Youth	Frontier Community Coalition	Goshen Community Development Coalition	Healthly Communities Coalition of Lyon and Storey Counties	Join Together Northern Nevada	Nye Communities Coalition	Partners Allied for Community Excellence	Partnership of Community Resources
					Community Domain										
✓				✓	Availability of Drugs	✓	✓	✓	✓	✓	✓	✓			✓
	✓			✓	Availability of Firearms										
✓	✓			✓	Community Laws and Norms Favorable Toward Drug Use, Firearms and Crime			✓	✓		✓	✓		✓	
				✓	Media Portrayal of Violence										
✓	✓		✓		Transitions and Mobility						✓	✓	✓		
✓	✓			✓	Low Neighborhood Attachment and Community Disorganization						✓	✓	✓	✓	
✓	✓	✓	✓	✓	Extreme Economic Deprivation			✓			✓	✓			
					Family Domain										
✓	✓	✓	✓	✓	Family History of the Problem Behavior										
✓	✓	✓	✓	✓	Family Management Problems	✓	✓	✓	✓		✓			✓	✓
✓	✓	✓	✓	✓	Family Conflict										✓
✓	✓			✓	Favorable Parental Attitudes and Involvement in the Problem Behavior				✓		✓	✓	✓	✓	
					School Domain										
✓	✓	✓	✓	✓	Academic Failure Beginning in Late Elementary School				✓	✓					✓
✓	✓	✓	✓	✓	Lack of Commitment to School	✓	✓				✓		✓		
					Individual / Peer Domain										
✓	✓	✓	✓	✓	Early and Persistent Antisocial Behavior										
✓	✓		✓	✓	Rebelliousness	✓	✓	✓							✓
✓	✓			✓	Gang Involvement										
✓	✓	✓	✓	✓	Friends who Engage in the Problem Behavior							✓		✓	
✓	✓	✓	✓		Favorable Attitudes Toward the Problem Behavior				✓	✓		✓	✓		
✓	✓	✓	✓	✓	Early Initiation of the Problem Behavior			✓	✓		✓				✓
✓	✓			✓	Constitutional Factors										

I. Youth Risk Behavior Survey Data (YRBS)

Every other year, the Nevada Department of Education administers the Youth Risk Behavior Survey (YRBS) as part of the United States Center for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance System. The CDC uses this data to measure the prevalence of priority health and safety behaviors that put youth at risk for significant health and social problems. The data is also used to monitor progress toward achieving relevant national health objectives for the year 2010. In 2001, Nevada combined selected questions from the Nevada Safe and Drug Free Schools and Communities Survey with the core YRBS questions. Also in 2001, the middle school students were surveyed for the first time. The following table presents the YRBS statistics for the years 1999, 2001, and 2003 for high school students only. The relevant YRBS data that is subsequently provided in this report for each domain includes only high school data.

Table 6: Youth Risk Behavior Survey Statistics for 1999, 2001, and the 2003 Surveys

	Students Surveyed	School Response Rate	Number of Participating Schools	Usable Surveys Used for Analysis	Percent Usable Surveys Obtained
1999	2,702	97%	73	1,677	62%
2001	2,214	95%	62	1,464	66%
2003	3,280	99%	84	1,982	60%

J. Prevention of Substance Abuse

In the past, BADA contracted with an interdisciplinary evaluation team comprised of members from the Research and Educational Planning Center at the University of Nevada, Reno, to evaluate the effectiveness of funded prevention programs throughout the state. This research team developed a data collection system to track individual participant demographics and service activities, risk and protective factors, and core outcome measures from 1999 until the end of 2004. Currently, this system is longer in use, and the Bureau is in the process of replacing it by the end of 2005.

Figure 3: Statewide Participants in Prevention Programs by Referral Source, (2004)

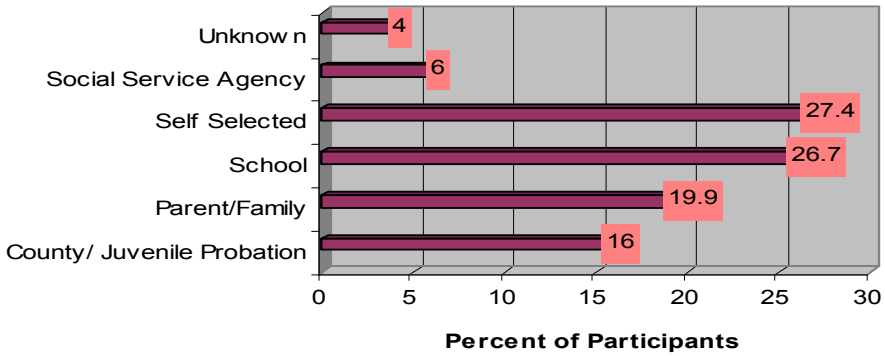
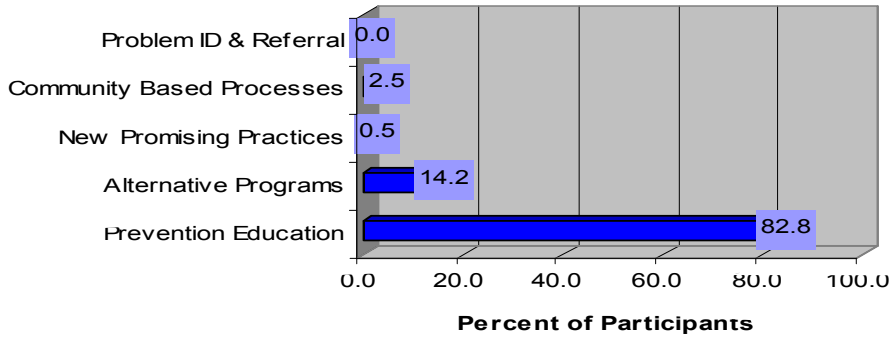


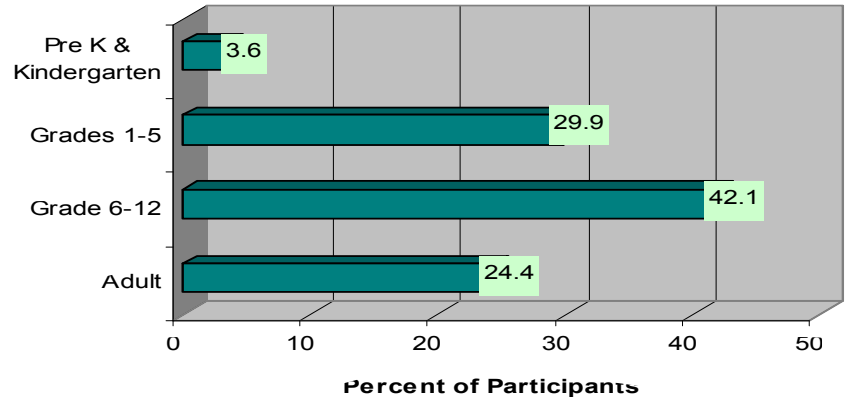
Figure 4: Statewide Participants in Prevention Programs by Strategy (2004)



BADA funded prevention programs reported 9,094 participants in SFY 2004. Of these participants, 53% were females and 47% were males. Participation by ethnicity was: 42.5% Whites, 28.0% Latinos, 20.3% African Americans, 4.0% Native Americans, 0.7% Asians, 0.7% Pacific Islanders, 3.2% Multi-ethnic, and 0.6% reported Other. The percentage of individuals referred to prevention programs by source are detailed in Figure 3, and those enrolled in the six different prevention strategies are detailed in Figure 4 and on the following page.

Program participants by school grade age are provided in Figure 5. BADA funded prevention providers use Evidence Based strategies, activities, or approaches, which have been shown through research and evaluation to be effective at preventing and/or delaying substance abuse. The six prevention strategies employed are detailed in the following page.

Figure 5: Statewide Participants in Prevention Programs by School Grade (2004)



Prevention Strategies

- **Information Dissemination:** This strategy provides an awareness and knowledge of the nature and extent of substance use, abuse, addiction, and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience with limited contact between the two. Information dissemination alone has not been shown to be effective at preventing substance abuse. In SFY 2004, Nevada's two clearinghouses distributed 458,600 pieces of literature and answered 1,213 requests for information.

- **Education:** This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment of abilities.

- **Alternatives:** This strategy provides for the participation of target populations in activities that exclude substance use, and assumes that constructive and healthy activities offset the attraction to alcohol and drugs, or meets the need filled by substance abuse activities; thereby, minimizing or preventing substance abuse activities among participants. Alternative activities alone have not been shown to be effective at preventing substance abuse.

- **Problem Identification and Referral:** This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

- **Community-Based Process:** This strategy focuses on enhancing the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implemented, interagency collaboration, coalition building, and networking.

- **Environmental:** This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

Substance Abuse Prevention Programs and Providers (SFY 2005)

Prevention services are classified as a proactive process of helping individuals, families, and communities to develop the resources needed to utilize and maintain healthy lifestyles. Through the Substance Abuse Prevention and Treatment Block Grant (SAPT), BADA funds only private nonprofit organizations and/or government agencies to directly reduce the impact of substance abuse in Nevada.
In State Fiscal Year 2005, BADA funded 38 Substance Abuse Prevention Providers in Nevada. These Prevention Providers are located in 12 of the 17 Nevada counties and run 75 programs with 12,144 participants. All current BADA-funded Substance Abuse Prevention Providers report their prevention program results each quarter. With these results BADA is able to assess the quality of substance abuse prevention services, maintain federally required information, develop and maintain infrastructure, continue verification of funding, support prioritized risk and protective factors, expand collaboration of prevention services and provide support for at-risk target populations.

Some of the data collection on participants of prevention programs, based on certain criteria, include type of evidenced-based program selections, prevention strategies and participant demographics. Evidence-based program selections are reviewed and approved by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). These program selections include:

- **Model Programs** are well-implemented and well-evaluated programs;
- **Effective/Promising Programs** have been implemented and evaluated sufficiently and are considered to be scientifically defensible;
- **Unproven Programs** include Principles of Effective Substance Abuse Prevention which are scientifically defensible principles that can help service providers design and implement programs that work.

In SFY 2005, of the 75 funded Evidence-based programs 36% were Model, 23% Effective/Promising, 25% Unproven and 25% Other Evidence Based Programs.

On the previous page the definitions of the six prevention strategies were explained in detail (page 16). All programs are structured based on one or more of the six Center for Substance Abuse Prevention (CSAP) strategies of substance abuse prevention. Of the funded prevention programs, the chosen prevention strategies for the evidence based models were as follows: 4% Community-based Process, 11% Information Dissemination, 57% Prevention Education, 24% Alternative Activities, 3% Problem Identification and Referral and 1% Environmental.

The following information is based on the data collection from all BADA funded prevention programs on participant demographics (see page next page for detailed pie charts):

- **Number of Persons**- 12,144 served
- **Gender**- 53% female and 47% male
- **Race/Ethnicity Category–** 52% white, 22% Hispanic, 15% Black/ African American, 11% combined for American Indian/Alaska Native, Asian, Native Hawaiian/ Pacific Islander, Other or Unknown
- **Age Group Categories–** 28% 5 to 11 years old, 17% 45 to 64 years old, 14% 12 to 14 years old, 14% 15 to 17 years old, 12% 25 to 44 years old and 15% combined for 18 to 20, 21 to 24 and 0 to 4 years old

Figure 6

Percentage of Prevention Program Participants by Gender, SFY 2005

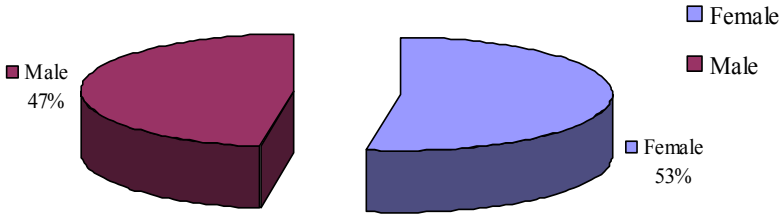


Figure 7

Percentage of Prevention Program Participants by Age Groups, SFY 2005

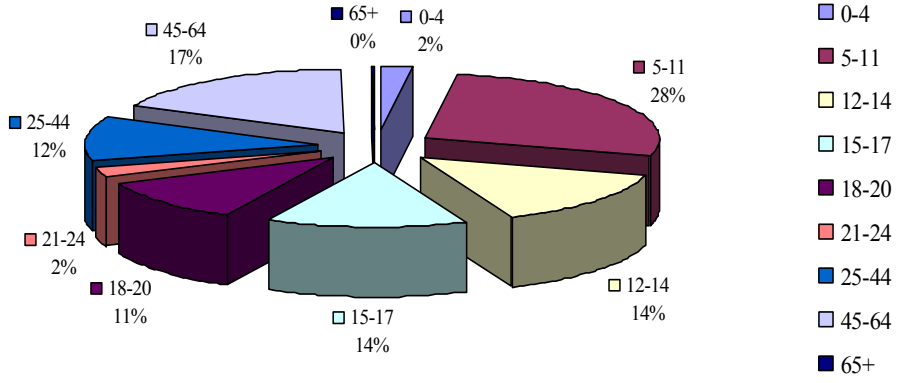


Figure 8

Percentage of Prevention Program Participants by Race/ Ethnicity Category, SFY 2005